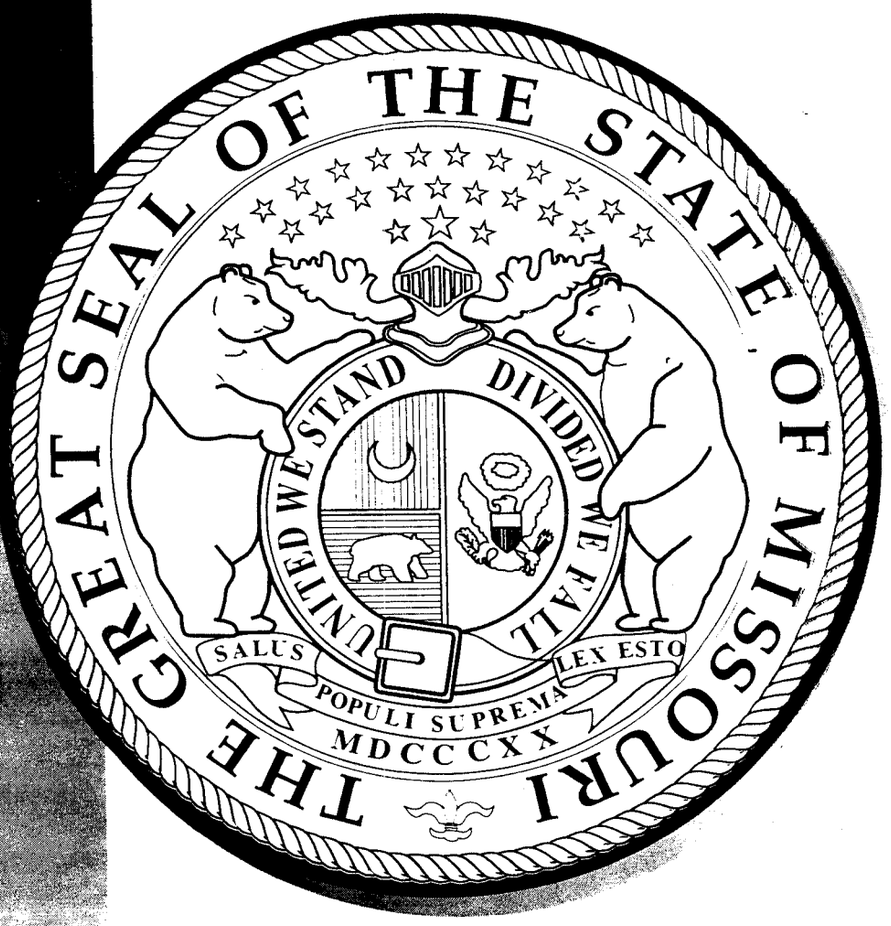
Attachment 4

Division of Purchasing
Vendor Manual

Not Provided



Vendor Manual

State of Missouri
Office of Administration
DMSION OF PURCHASING
AND MATERIALS MANAGEMENT

Attachment 5

Quality Assessment and Improvement Plan

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

☆ QUALITY ASSESSMENT AND IMPROVEMENT PLAN ☆

☆ *Purpose* ☆

To assure access to quality service in the Managed Care Plus (MC+) Program, the Division of Medical Services, Quality Assessment Unit will employ a variety of methods and tools to measure outcomes of service that are provided through the health plans and promote the process of ongoing quality improvement. Quality of care will be measured and evaluated in a regular, ongoing manner utilizing the following approach.

☆ *Goal* ☆

The goal is to monitor health care services provided to MC+ members by the health plans in compliance with Federal, State, and contract requirements; and to develop a process through which the Division of Medical Services can collegially work with the health plans to establish objectives and timetables for improvement of service delivery where indicated.

☆ *Overview* ☆

The plans must meet program standards for quality improvement, systems, member services, provider services, record keeping, organizational structure, adequacy of personnel, access standards, and data reporting as outlined in the managed care contract. In addition, quality standards must meet or exceed the requirements of 42 CFR 434.34.

The Quality Assessment process includes an internal review administered by the health plan, an internal review by the state, and an annual external review administered by an independent PRO or PRO-like entity. Components of the quality assessment process include the following:

1. Plan Report of Quality Assessment and Improvement

   A. The plans will provide the State with regular reports of internal utilization and quality assessment reviews. Frequency and types of reports include:

      1. Quarterly Reports: Quarterly reports are due 45 working days following the last day of the quarter. Required reports are as follows:

a. Summary of Member Complaints and Grievances: This report **will** contain the total number of informal complaints and the rate of complaints by medical and non-medical nature of complaint. The rate of Medical complaints will be reported using categories such as quality of care, days to appointment, transportation, specialist request, request for interpreter, and denial of service. The rate of non-medical complaint will be reported by **categories** such as doctor's office staff, plan office staff, office waiting **time.** Resolutions to complaints are to be reported for both categories. The total grievances and grievance rates will be reported using the same categories as for complaints and grievances.

b. Total provider complaints and grievances will **be** reported by nature of complaint or grievance such as quality of care, denial of referral request, denial of claim, and lack of timely payment. Included in the report will be resolutions to complaints and grievances.

c. Total number of transfers among primary care providers **will be** reported by reasons for request such as accessability, acceptability, and quality of care. The report will include action taken to resolve requests.

2. Annual Reports: A quality assurance report will be submitted annually after the contract effective date. Utilization and clinical outcome data will be included in the report. See Attachment 1 **for** a list of quality assessment indicators to be used for reporting and Attachment 2 for details of plan reporting. Reports will include **a** summary of data analysis for each indicator with trends identified for focused study, results of focused studies, corrective action taken, and outcome of action applied. **The** report will also contain other quality issues and actions identified through the internal plan quality assessment and improvement process. These may include, for example, focused studies which target specific health issues unique to the population or results of random primary care medical chart audits.

   Documentation of monitoring and follow up on action items **will be** maintained in the minutes of meetings of the health plan Quality Assessment and Improvement Committee!. A summary update of activities associated with monitoring and action items will **be** included with required quarterly reports on complaints, grievances, and transfers.

Attachment 3 provides a calendar of plan reporting periods.

The health plan will collect and assist the State in collecting annual member satisfaction data through application of a uniform instrument to a randomly selected sample of its members prior to the end of the third quarter of the contract year. The State will tally the results of the surveys and the results will be published.

II. State Review

A. The State will collect and analyze clinical and utilization data from a variety of sources so as to support the health plans in their efforts toward the continuous improvement in the provision of health care services, The frequency and types of reports include:

1. Quarterly Reports: Quarterly reports will be compiled and presented through regularly scheduled meetings of the State Quality Assessment & Improvement Advisory Group. Quarterly reports will include the following:
   a, Secondary source data will be reviewed for trends which may indicate opportunities for improvement in service delivery. Identified problematic areas may become targeted areas for review during on-site audit and/or external review.
   b. Reports of complaints and grievances received by the State will be compiled and reported by category.
   c. Plan transfers between plans and disenrollments will be compiled and reported by category of request.
   d. Reports of issues which have come to the State as episodic occurrences will be collected, analyzed, and reported. Reports will include identified trends and recommendation for action to be taken.

2. Annual Reports:
   a. Performance outcomes and health status indicators will be analyzed and reported.
   b. The Consumer Satisfaction Survey will be analyzed and reported by health plan by standard report categories.

   Attachment 4 provides a list of indicators which will be included in state reports.

B. The State will conduct on-site plan **reviews** at **six months** in the first contract year and annually thereafter. The **reviews** will include:

1. Review of a sample number **of** Medicaid records from network providers.
2. **Review** of credentialing and recredentialing processes for plan network providers.
3. Review of external accreditation preparation and results.
4. Review of documentation in support of outreach activities and ongoing provider education activities.
5. Results and supporting material relating to Medicaid **HEDIS**, outcomes measures, focused studies, and medical chart audits,
6. Visits to a sample of provider site locations. (Optional)

III. External Quality Assessment Review

A. An External Review and Focused Study will target specific areas of concern which come to the attention of the individual plan or the State through Internal Quality Assessment and Improvement Programs or other monitoring activities. The external reviews will utilize a number of review methods to validate encounter data and compare care delivery recommended in accordance with identified practice guidelines. Methods may include:

1. Medical chart reviews
2. Health Plan case management files
3. Surveys of clinics and providers
4. Data analysis
5. Administrative oversight and QA & I implementation
6. **Focused** studies of certain aspects of care

B. The External Review Organization will compile and provide a summary of findings and recommendations after a review exit conference with the health plan administrative and clinical management staff.

IV. Annual Reports

The State will provide an annual report compiled from findings and recommendations of all segments of the Quality Assessment Program to the Statewide Quality Assessment and Improvement Advisory Group. Plan report cards may be produced utilizing risk adjusted reported information.

☆ PLAN REPORTED MC+ QUALITY INDICATORS ☆

GENERAL REQUIREMENTS: (Quarterly Reports).

1. Complaints and grievances with resolutions.
2. Number and reasons for transfers among PCPs

   Quarterly Report due dates are calculated 45 working days following the end of the quarter.

HEDIS REQUIREMENTS: (Annual Reports)

3. (H) Childhood Immunization Status (2 year old)
4. (H) Adolescent Immunization Status
5. (H) Well child Visits in the First 15 Months of Life
6. (H) Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life
7. (H) Adolescent Well-Care Visits
8. (H) Cervical Cancer Screening
9. (H) Follow-up after hospitalization for mental health disorders,
10. (H) Check-ups After Delivery
11. (H) Annual dental visit
12. (H) Ambulatory Care
13. (H) Mental Health Utilization - Percentage of Members Receiving IP/Day\Night Care and Ambulatory Service

OTHER DATA: (Annual Reports)

14. Monitoring of 24 hour coverage.
15. Member Satisfaction Survey (State Provided)
16. Chemical Dependency Utilization - Percentage of Members Receiving IP/Day\Night Care and Ambulatory Service
17. Sentinel Events (Occurrences)

(H) = HEDIS **Measure**

☆ MANAGED CARE PLUS (MC+) ☆
Outcome Measures Report Requirements

❶ Summary of complaints and grievances with resolutions,

- To be reported quarterly. This report is due 45 days after the end of the reporting period.
- This report will be rate based. The numerator will be all complaints/grievances/appeals filed by members and providers during the reporting period. The denominator data will be the member months for the same period.
- The report will be divided as follows:
  - Member Medical complaints
  - Member Medical grievances and appeals
  - Member Non-medical complaints
  - Member Non-medical grievances and appeals
  - Provider Complaints
  - Provider Grievances and appeals
- The results are reported by the following categories:
  - Member Medical Complaints
    - quality of care
    - days to appointment
    - denial of specialist referral
    - denial of services
    - other
  - Member Nonmedical Complaints
    - doctor's office staff behavior
    - transportation
    - officewaiting time
    - denial of claims
    - interpreter issues
    - other
  - Provider medical complaints
    - quality of care
    - denial of referral request
    - denial of services
    - other
  - Provider non-medical complaints
    - transportation
    - interpreter issues
    - denial of claims
    - other

Note: If plan has additional resolution activities (such as arbitration) available to the member, mark the appeal as pending until these activities are completed.

❷ Number of requests for transfer of primary care provider and actions taken.
- To be reported quarterly.
- The health plan will report the incidence of transfer requests, total and by type per 1000 members. These requests will be adjusted to include only the requests from members who were not assigned to their PCP through the auto assign method,

Total:

(Total number of requests - number of post-auto assian requests)
Member months

By Type:

(Number of requests [by type*] - number of post auto assign requests)
Member months

* *Type are to be reported per 1000 members using the following four categories:*
- ***Accessibility***
- ***Acceptability***
- ***Quality***
- ***Other***

- The health plan will also report the rate that the request for transfers were granted.

Request granted rate (adjusted for PCP auto assignment):

(Total number of requests granted - number of post-auto assign requests granted)
(Total number of requests - number of post-auto assign requests)

6 HEDIS indicators, indicators numbered 3 through 13, will be collected in accordance with HEDIS 3.0 guidelines for the numerators and denominators. The plan must indicate which method, hybrid or administrative, was utilized to collect the data.

❹ Indicator 14, a summary report of the plans findings regarding internal monitoring of 24 hour coverage (Provider availability.) will be attached to the annual report.

❺ Indicator 15, Consumer Satisfaction Survey results will be provided by the State.

Note: State will develop the satisfaction survey in collaboration with the glans, the Quality Assessment and Improvement Advisory Group and the Consumer Advisory Committee.

❻ Indicator 16, Chemical Dependency Utilization will be collected in accordance with the HEDIS indicators with one exception, the requirement for continuous enrollment has been omitted.

❼ Indicator 17, Sentinel Events, are quality issues and actions identified through the health plans' internal quality assessment and improvement process and will be included in the annual report.

❽ Encounter data will be submitted as defined in the RFP.

☆ MC+ QUALITY ASSESSMENT PROGRAM ☆

Quality Indicator Reporting Periods

The following reporting periods have been defined for reporting of quality indicators by health plans participating in the MC+ program

REGION	QUARTERLY REPORTING *(Due 45 **WORKING** days following the last day of the quarter.)*			ANNUAL REPORTING		ANNUAL & CHART REVIEW
	Quarter	Reporting Periods	Report Due Dates	Reporting Period	Report Due Date	
Eastern *Year 2*	1	October 1 - December 31, 1996	March 10, 1997	January 1 - December 31, 1997	June 30, 1997 (Year 1) June 30, 1998 (Year 2)	September - October 1997
	2	January 1 - March 31, 1997	June 4, 1997			
	3	April 1 - June 30, 1997	September 3, 1997			
	4	July 1 - September 30, 1997	December 5, 1997			
Central *Year 2*	1	April 1 - June 30, 1997	September 3, 1997	January 1 - December 31, 1997	June 30, 1997 (Year 1) June 30, 1998 (Year 2)	February - March 1998
	2	July 1 - September 30, 1997	December 5, 1997			
	3	October 1 - December 31, 1997	March 10, 1998			
	4	January 1 - March 31, 1998	June 3, 1998			
Western *Year 1*	1	January 1 - March 31, 1997	June 3, 1997	January 1 - December 31, 1997	June 30, 1998	February 1998
	2	April 1 - June 30, 1997	September 3, 1997			
	3	July 1 - September 30, 1997	December 3, 1997			
	4	October 1 - December 31, 1997	March 5, 1998			
Northwestern *Year 1*	1	January 1 - March 31, 1997	June 3, 1997	January 1 - December 31, 1997	June 30, 1998	February 1998
	2	April 1 - June 30, 1997	September 3, 1997			
	3	July 1 - September 30, 1997	December 3, 1997			
	4	October 1 - December 31, 1997	March 5, 1998			

☆ Attachment 3 ☆

☆ MANAGED CARE PLUS (MC+) ☆

State Reports
(Secondary-Source Reporting)

DMS INTERNAL DATA SOURCES:

1. Complaints and grievances.
2. Number and reasons for transfers between plans and disenrollments.

DOH DATA SOURCES:

3. (H) Well child Visits in the First 15 Months of Life
4. (H) Adolescent lmmuniration Status
5. (H) Number of Acute inpatient behavioral health and average length of stay
6. Number of enrollees seeking initial prenatal care visit during:"
   a. Preconception
   b. First trimester
   c. Second trimester
   d. Third trimester
7. Birth weight - total number of births by weight category for each live birth.*
   - <500 Gms. ____
   - 500-1499 Gms. ____
   - 1500-1999 Gms. ____
   - 2000-2499 Gms. ____
   - ≥2500 Gms. ____
   - Stillborn fetuses____
8. All delivered single or multiple live or still born fetus(es) of greater than or equal to 22 weeks gestation.*
9. Pregnancy outcome*
   a. Fetal loss >29 weeks
   b. Number of live births by:
      type of birth (cs, vbac, vaginal)
10. Total number of members provided prenatal care.*
11. Sexually Transmitted Diseases*
    a. Chlamydia - ICD 099.53
    b. Gonorrhea - ICD 091.0
    c. Syphilis - ICD 98.0 and 97.9
12. Percent of pregnant women on WIC*
13. Inadequate Prenatal Care*
14. Smoking During Pregnancy"
15. Spacing <18 months since last birth*
16. Births to mothers <18 years of age*
17. Family Planning Opportunities*

(H) = HEDIS Measure
*Collected form Department of Health Database.

Attachment 6

Forms used by Internal Medical Review Committee

Attachment 6 6/3/97

DIVISION OF MEDICAL SERVICES
INTERNAL MEDICAL REVIEW COMMITTEE
RECORD REQUEST FORM

Date: _____

TO:

Name: _____

Company: _____

Fax Number: _____

REQUEST:

Federal Regulation 42 CFR 431.107 provides for the required provider agreement and specifies that providers, "on requests, furnish to the Medicaid agency," records to disclose the extent of services furnished to Medicaid recipients and any information regarding payments claimed by the provider. This is included in the Provider Agreement where "failure to submit" or "retain adequate documentation" may result in recovery of payments or sanctions to participation. State regulation 13 CSR 70-3.030 defines "records" and "adequate documentation," and states records must be retained and made available on request to the Medicaid agency or its authorized agents. The managed care contract also requires health plans and its providers to maintain records and furnish them to the state upon quest.

A release of information does not need to be secured from the recipient to forward the requested information due to the above federal and state regulation.

The following information is requested for clinical review by the Division of Medical Services Internal Medical Review Committee.

Member/Recipient Name: _____

DCN: _____ DOB: _____

Date(s) of Service Provided or Denied: _____

Documents requested: _____

_____

_____

_____

Comments: _____

_____

_____

_____

Division of Medical Services Staff Signature: _____

Please fax or overnight the above information requested within 4 working days to:

Division of Medical Services
615 Howerton Court
Jefferson City, MO 65109

Fax: 573/526-4650
Phone: 573/751-3399

6/3/97

DIVISION OF MEDICAL, SERVICES;
INTERNAL MEDICAL REVIEW COMMITTEE
REQUEST FOR REVIEW FORM

INFORMATION REQUIRED FOR COMMITTEE TO REVIEW CASE

Date: _____ Requestor. _____

Approval/Management's Signature: _____

MC+ HEALTH PLAN/FEE-FOR-SERVICE PROVIDER INFORMATION

Contact Name _____

Health Plan/Provider _____

Address _____

Phone Number _____ Fax Number _____

MEMBER/RECIPIENT INFORMATION

Member/Recipient Name: _____

DCN: _____ DOB: _____

Has recipient/provider contacted:

Health Plan's Member Services	*Yes* _____ No _____
Health Plan's Provider Services	*Yes* _____ No _____
Filed a complaint ___ grievance ___ appeal ___ with the health plan (please check what has been filed with the health plan)	*Yes* _____ No _____

If any documentation has been *requested,* please specify what has been requested, who it has been requested from, the expected arrival date and to whom it is being sent.

_____

_____

DESCRIPTION OF REQUEST

_____

_____

_____

_____

_____

_____

_____

Respond to (please include *address* if someone other than DMS personnel):

_____

_____

Please forward this form and any other information to: SURS Unit